STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675717	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Rafael Nursing and Rehabilitation Center	3050 Sunnybrook Rd Corpus Christi, TX 78415

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50969 Based on interview, observation and record review, the facility failed to develop a comprehensive person-centered care plan based on assessed needs that included measurable objectives and timeframes to meet the resident's medical, nursing, mental, and psychosocial needs and describes the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 (Resident #43) of 5 residents reviewed for comprehensive person-centered care plans. The facility failed to develop and implement Resident #43 ' s care plan to include oxygen therapy. This failure could affect the resident by placing them at risk for not receiving care and services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The findings included: In an observation on 03/04/2025 at 11:00 AM of Resident #43, revealed he did not have any oxygen on, and there was no oxygen concentrator, tubing or other equipment in his room. Record review of Resident #43 ' s face sheet dated 03/05/25 revealed a [AGE] year-old-male with an admitted [DATE]. Diagnoses include COPD (Chronic Obstructive Pulmonary Disease is a lung condition caused by damage to the airways and alveoli, usually from smoking or other irritants). Record review of Resident #43 ' s Quarterly MDS assessment dated [DATE], Section C, Cognitive Patterns, revealed a BIMS score of 11 (moderately impaired cognition). The MDS did not indicate anything regarding oxygen or respiratory therapy. Record review of Resident #43 ' s physician orders revealed an order dated 03/04/25 for Oxygen 2 liters via nasal cannula to maintain saturations >92% as needed for SOB; it also revealed an order dated 01/08/25 and discontinued on 03/04/25 for Oxygen 2-4 LPM as needed for SOB with saturations <93%. Record review of Resident #43 ' s care plan on 03/05/25 revealed no care plan for oxygen, to include no oxygen diagnosis on the care plan, no oxygen status on the care plan, no oxygen orders on the care plan, no oxygen parameters on the care plan, and no oxygen equipment listed on the care plan. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN-G on 03/04/25 at 11:35 AM, she stated that the nurses utilized the care plans to determine specific things about the residents ' orders, such as oxygen parameters, foley catheters, EBP precautions, preferences, likes and/or dislikes. She stated that the care plans were updated by the MDS nurse and IDT team. In an interview with the MDS Nurse on 03/05/25 at 5:59 PM, she stated she reviewed Resident #43 ' s care plan, and the oxygen care plan was not there, but it should have been. She stated if things were not care planned appropriately residents may not get the appropriate care they needed. She also stated the care plan was usually updated by the IDT team. In an interview with the DON on 03/06/25 at 9:17 AM, he stated the MDS nurses typically updated the care plans, but they were new to it and still learning. He stated if he was putting an order in himself, he went ahead and clicked over to the care plan and updated it so that he knew it was done, but also the IDT team met, reviewed, revised, and updated care plans. He stated the care plan was there to help the nurses to understand more about what was went on with each resident, and without the care plan, the resident may not get the appropriate care or treatment they needed. He also stated that oxygen was something that should have been care planned. In an interview with ADON-F on 03/06/25 at 2:15 PM, she stated that care plans were updated by MDS and the IDT team. She stated if it was a clinical care plan, it was usually updated by the MDS nurse, and Oxygen was something that should have been care planned. She also stated that care plans were used by the nurses to determine specific things about the residents ' orders, diagnoses, preferences, likes, needs, wants, parameters, and if not added or updated, important care could be missed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51216 Based on observations, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received assistance devices to prevent accidents for one of five residents (Resident #103) reviewed for accidents and hazards. The facility failed to ensure floor mats were in place beside Resident #103 ' s right side of the bed. This failure could place residents at risk for an injury or a major injury. The findings include: Record review of Resident #103 face sheet, dated 03/05/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #103 had a diagnosis which included Benign Paroxysmal Vertigo (a feeling of spinning), Unspecified Ear. Record review of Resident #103's Significant Change Minimum Data Set assessment dated [DATE] indicated she had Cerebrovascular accident (stroke), muscle wasting and other lack of coordination. The assessment indicated Resident #103's brief interview of mental status score was 12-moderately impaired mental status. The assessment did not indicate any prior falls. Record review of Resident #103's comprehensive care plan dated 03/03/25 indicated The resident was at risk for falls and had actual falls: 12/23/24 The resident had an actual fall with minor injury to right cheek related to poor balance, unsteady gait 02/17/25 The resident had an actual fall on 2/17/25 with no injury 02/22/25 with no injury. Record review of Resident #103's physician order summary dated 02/23/24 revealed Floor mats at bedside every day shift and in the evening. Observation on 03/04/25 at 9:30 AM revealed Resident #103 was lying in her bed watching television. There was a floor mat positioned on the left side of the bed and on the right side of her bed the mat was leaning against the wall instead of being positioned on the floor beside the right side of her bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with CNA A on 03/05/25 at 09:31 AM revealed Resident #103's mats were to be at each side of her bed on the floor. She stated the CNAs were responsible in making sure that mats were placed correctly on the floor every time they entered the resident's room. CNA A stated Resident #103 was bathed in the morning and the floor mat may have been moved to approach the wheelchair to take Resident #103 to the shower or the mat may have been moved during breakfast time to put the bedside table for Resident #103 to eat. CNA A said she did not remove the floor mat and could recall the right-side floor mat being on the floor beside the bed when she arrived on duty at 6:00 AM. CNA A said Resident #103 needed both floor mats on the floor beside the bed to prevent injury in case she fell because she had made prior attempts to get out of bed without assistance. In an interview with LVN B on 03/04/25 at 04:55 PM revealed he stated he did not notice Resident #103's floor mat not in position on the left side of the floor. LVN B said Resident #103 needed a floor mat beside each side of her bed to prevent injury in case of a fall. LVN B said it was the his and the CNA's responsibility to ensure the floor mats were correctly positioned throughout their shift. Interview with the DON on 03/06/25 at 2:35 PM, the DON stated the floor mats were used to prevent injuries in case of a fall. The DON stated the floor mats should be at each side of the bed if the bed was centered in the room. The DON said the nurses and CNAs were responsible for monitoring the position of the floor mats. The DON stated Resident #103 could injure herself if the floor mat was not properly placed on the floor beside the bed. The DON said injuries could include bruising, skin tears, and fractures. The DON said he and the ADON conducted daily rounds to monitor preventive devices were placed correctly. Record review of the facility's Fall Prevention Program policy dated 05/24/22 reflected All residents will be assessed for the risk for falls at the time of admissions, on a quarterly basis, and upon significant change in condition thereafter. Based on the results of this assessment, specific interventions will be to minimize falls and avoid repeat falls and minimize falls resulting in significant injury 3. The following is a list of commonly used interventions that may be considered to minimize falls and injury . K. Utilizing adaptive equipment such as - walker, cane, grab bars, etc.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51216 Based on observation, interview and record review, the facility failed to ensure that residents who needed respiratory care were provided such care consistent with professional standards of practice, physicians orders, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 3 (Resident #7) residents reviewed for respiratory care. The facility failed to ensure Resident #7's oxygen concentrator administered oxygen at the correct setting of 2 liters per minute. Resident #7's oxygen concentrator was set at 3 liters per minute on 03/04/2025 at 8:33 AM and at 4:55 PM. This failure places residents who receive respiratory care at an increased risk of developing respiratory complications, and a decreased quality of care. The findings included: Resident #7's face sheet dated 03/04/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #7 had a diagnosis which included Chronic Obstructive Pulmonary disease (a common lung disease causing restrictive airflow and breathing problems), with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions), inflammation and narrowing of the airways, leading to restricted airflow and difficulty breathing , along with acute respiratory, failure, asthma uncomplicated. Record review of Resident #7's Minimum Data Set assessment section O, Special Treatments, Procedures and Programs, dated 01/20/25 reflected continuous oxygen use. Record review of Resident #7's comprehensive care plan dated 01/21/25 reflected The resident has altered respiratory status/difficulty breathing related to ACUTE RESPIRATORY FAILURE WITH HYPOXIA. Oxygen settings: Oxygen at 2 Liters nasal cannula as needed. Date Initiated: 12/11/2023. Record review of Resident #7's physician order summary dated March 2025 reflected Oxygen at 2 Liters a minute per Nasal Cannula as needed to maintain oxygen saturation greater than 92% as needed for hypoxia, start date 12/13/23. Observation and interview with Resident #7 on 03/04/25 at 8:33 AM revealed she was awake, alert and oriented to person, place and time. Resident #7 had a nasal cannula in place that was connected to an oxygen concentrator that was set at 3 liters per minute. Resident #7 said she was able to apply and remove the oxygen tubing at her convivence but did not touch the concentrator setting. Observation of Resident #7 on 03/05/25 at 4:45 PM revealed she had her oxygen cannula in both nares with the tubing connected to the oxygen concentrator that was set at 3 liters per minute. Interview with CNA A on 03/05/25 at 4:49 PM revealed she stated the oxygen concentrator was set at 3 liters. CNA A also stated she did not know how much oxygen Resident #7 was ordered. CNA A said she did not touch the oxygen, and the nurse was responsible for ensuring correct oxygen administration. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LVN B on 03/05/25 at 4:55 PM revealed he stated that at the start of every shift the LVNs are responsible for ensuring the settings on the oxygen concentrators match the physician orders. Upon the state surveyors request, LVN B checked Resident #7's oxygen concentrator and said it was set at 3 liters per minute. LVN B said he thought the order could be between two to three liters per minute but could not recall the exact amount. After LVN B reviewed Resident #7's physician order he said the order indicated 2 liters per minute. LVN B said he had not checked Resident #7's oxygen concentrator settings yet, despite his shift beginning at 6 AM. LVN B stated not having the correct setting can cause high levels of carbon dioxide in the blood. Interview with the DON on 03/05/25 at 05:51 PM revealed he stated the physician orders should be followed as directed. The DON said the nurses were responsible for checking the oxygen concentrators for correct setting and administration in the morning at beginning of their shift. The DON stated since Resident #7 had Chronic Obstructive Pulmonary disease, too much oxygen could make her ill and increase her carbon dioxide levels. The DON said he and ADON conduct morning rounds to check oxygen concentrators, and he had not received any reports of inaccurate settings. Record review of the facility's Oxygen Administration policy and procedure dated October 2010 reflected The purpose of this procedure is to provide guidelines for safe oxygen administration .1. Verify that there is a physician's order for his procedure. Review the physician's orders or facility protocol for oxygen administration Steps in procedure .Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49157 Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 2 of 8 (Resident #75 and Resident #110) residents reviewed for accurate procedures for medication administration. 1a. The facility failed to ensure LVN C checked and/or documented an accurate blood pressure for Resident #75 before administering Resident #75's blood pressure decreasing medication that had physician ordered hold parameters on 5 of 12 opportunities from 02/01/25 to 03/04/25. 1b. The facility failed to ensure LVN I checked and/or documented an accurate blood pressure for Resident #75 before administering Resident #75's blood pressure decreasing medication that had physician ordered hold parameters on 10 of 11 opportunities from 02/01/25 to 03/04/25. 2a. The facility failed to ensure LVN E checked and/or documented an accurate blood pressure for Resident #110 before administering or holding Resident #110's blood pressure decreasing medication that had physician ordered hold parameters on 5 of 6 opportunities from 02/13/25 to 03/04/25. 2b. The facility failed to ensure LVN B documented an accurate blood pressure and pulse for Resident #110 when he held Resident #110's blood pressure decreasing medication on 1 of 6 opportunities from 02/13/25 to 03/04/25. 2c. The facility failed to ensure LVN I checked and/or documented an accurate blood pressure reading for Resident #110 before administering Resident #110's blood pressure decreasing medication on 2 of 4 opportunities from 02/13/25 to 03/04/25. 2d. The facility failed to ensure LVN J did not administer Resident #110's blood pressure decreasing medication when Resident #110's blood pressure was below the physician ordered hold parameters on 4 of 5 opportunities from 02/13/25 to 03/04/25. 2e. The facility failed to ensure LVN E did not administer Resident #110's blood pressure decreasing medication when Resident #110's blood pressure was below the physician ordered hold parameters on 1 of 6 opportunities from 02/13/25 to 03/04/25. 2f. The facility failed to ensure LVN K did not administer Resident #110's blood pressure decreasing medication when Resident #110's blood pressure was below the physician ordered hold parameters on 1 of 1 opportunity from 02/13/25 to 03/04/25. 2g. The facility failed to ensure LVN L did not administer Resident #110's blood pressure decreasing medication when Resident #110's blood pressure was below the physician ordered hold parameters on 1 of 5 opportunities from 02/13/25 to 03/04/25. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2h. The facility failed to ensure LVN E checked and/or documented an accurate blood pressure reading for Resident #110 before administering Resident #110's blood pressure increasing medication on 6 of 6 opportunities from 02/13/25 to 03/04/25. 2i. The facility failed to ensure LVN B checked and/or documented an accurate blood pressure reading for Resident #110 before administering Resident #110's blood pressure increasing medication on 3 of 13 opportunities from 02/13/25 to 03/04/25. 2j. The facility failed to ensure LVN I checked and/or documented an accurate blood pressure reading for Resident #110 before administering Resident #110's blood pressure increasing medication on 2 of 7 opportunities from 02/13/25 to 03/04/25. 2k. The facility failed to ensure LVN J checked and/or documented an accurate blood pressure reading for Resident #110 before administering Resident #110's blood pressure increasing medication on 1 of 5 opportunities from 02/13/25 to 03/04/25. 2l. The facility failed to ensure LVN D checked and/or documented an accurate blood pressure reading for Resident #110 before administering Resident #110's blood pressure increasing medication on 1 of 11 opportunities from 02/13/25 to 03/04/25. 2m. The facility failed to ensure LVN L checked and/or documented an accurate blood pressure reading for Resident #110 before administering Resident #110's blood pressure increasing medication on 1 of 5 opportunities from 02/13/25 to 03/04/25. 2n. The facility failed to ensure LVN I did not administer Resident #110's blood pressure increasing medication when Resident #110's blood pressure was above the physician ordered hold parameters on 2 of 7 opportunities from 02/13/25 to 03/04/25. 2o. The facility failed to ensure LVN C did not administer Resident #110's blood pressure increasing medication when Resident #110's blood pressure was above the physician ordered hold parameters on 1 of 6 opportunities from 02/13/25 to 03/04/25. These failures could place residents at risk of medication administration errors, not receiving the intended therapeutic effects of the medications, and could contribute to adverse reactions resulting in a decline in health and/or , hospitalization . The findings included: 1. Record review of Resident #75's admission record reflected [AGE] year-old male admitted to the facility on [DATE] with an original admitted [DATE]. Resident #75's diagnoses included essential (primary) hypertension (high blood pressure), hyperlipidemia (high cholesterol), peripheral vascular disease (reduced blood flow to the arms and legs due to narrowed blood vessels), and type 2 diabetes (condition in which the body does not use insulin properly resulting in persistently high blood sugars). Record review of Resident #75's quarterly MDS dated [DATE] reflected a BIMS score of 13 which indicated Resident #75 was cognitively intact. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #75's care plan dated 03/02/24 reflected the focus of, the resident has hypertension (HTN) with the goal, the resident will remain free of s/sx of hypertension through the review date. The interventions included, avoid taking the blood pressure reading after physical activity or emotional distress, and, give anti-hypertensive medications as ordered, monitor for side effects such as orthostatic hypotension (blood pressure decrease when changing position from laying to sitting or sitting to standing) and increased heart rate, and effectiveness, initiated on 03/03/25. Record review of Resident #75's order summary report reflected an order dated 11/20/24 to start on 11/21/24 at 9:00am for Lisinopril (a blood pressure decreasing medication) oral tablet 10mg. Give 1 tablet by mouth one time a day for High B/P. Hold if BP <110/60. Record review of Resident #75's February and March 2025 blood pressure tab and eMAR in PCC reflected Resident #75's blood pressure was checked 9 out of 24 days that Resident #75 was at the facility and received his blood pressure decreasing medication: 1a, b. On 02/01/25 at 9:43am, LVN C checked Resident #75's blood pressure; it was 136/78. LVN C documented that blood pressure on the eMAR and documented that Resident #75 received his Lisinopril. On 02/02/25 there was no record of Resident #75's blood pressure being checked; however, LVN C documented Resident #75's blood pressure on the eMAR as 136/78, the same BP as 02/01/25, and that Resident #75 received his Lisinopril. On 02/03/25 and 02/04/25, there was no record of Resident #75's blood pressure being checked; however, LVN I documented Resident #75's blood pressure on the eMAR as 136/78 on both days, the same BP as 02/01/25 and 02/02/25 and that Resident #75 received his Lisinopril on both days. On 02/05/25 at 8:56am, LVN C checked Resident #75's blood pressure; it was 141/83. LVN C documented that blood pressure on the eMAR and documented that Resident #75 received his Lisinopril. On 02/06/26, there was no record of Resident #75's blood pressure being checked; however, LVN C documented Resident #75's blood pressure on the eMAR as 141/83, the same BP as 02/05/25, and that Resident #75 received his Lisinopril. On 02/07/25, 02/08/25, and 02/09/25 there was no record of Resident #75's blood pressure being checked; however, LVN I documented Resident #75's blood pressure on the eMAR as 141/83 on all three days, the same BP as 02/05/25 and 02/06/25, and that Resident #75 received his Lisinopril. On 02/11/25 at 10:02am, LVN C checked Resident #75's blood pressure; it was 147/86. LVN C documented that blood pressure on the eMAR and documented that Resident #75 received his Lisinopril. On 02/12/25, there was no record of Resident #75's blood pressure being checked; however, LVN I documented Resident #75's blood pressure on the eMAR as 147/86, the same BP as 02/11/25, and that Resident #75 received his Lisinopril. On 02/13/25, Resident #75 was out of the facility; however, LVN I documented Resident #75's blood pressure on the eMAR as 147/86, the same BP as 02/11/25 and 02/12/25, and that Resident #75 did not receive his Lisinopril because he was out of the facility without medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/17/25 at 9:12am, LVN M checked Resident #75's blood pressure; it was 145/72. LVN M documented that blood pressure on the eMAR and documented that Resident #75 received his Lisinopril. On 02/18/25, there was no record of Resident #75's blood pressure being checked; however, LVN I documented Resident #75's blood pressure on the eMAR as 145/72, the same BP as 02/17/25, and that Resident #75 received his Lisinopril. On 02/19/25, there was no record of Resident #75's blood pressure being checked; however, LVN C documented Resident #75's blood pressure on the eMAR as 145/72, the same BP as 02/17/25 and 02/18/25, and that Resident #75 received his Lisinopril. On 02/20/25 at 9:11am, LVN C checked Resident #75's blood pressure; it was 146/82. LVN C documented that blood pressure on the eMAR and documented that Resident #75 received his Lisinopril. On 02/21/25, there was no record of Resident #75's blood pressure being checked; however, LVN I documented Resident #75's blood pressure on the eMAR as 146/82, the same BP as 02/20/25, and that Resident #75 received his Lisinopril. On 02/22/25 and 02/23/25, Resident #75 was not at the facility. On 02/24/25 and 02/25/25, there was no record of Resident #75's blood pressure being checked; however, LVN C documented Resident #75's blood pressure on the eMAR as 146/82, the same BP as 02/20/25 and 02/21/25, and that Resident #75 received his Lisinopril. On 02/26/25 and 02/27/25, there was no record of Resident #75's blood pressure being checked; however, LVN I documented Resident #75's blood pressure on the eMAR as 146/82, the same BP as 02/20/25, 02/21/25, 02/24/25, and 02/25/25, and that Resident #75 received his Lisinopril. On 02/28/25 at 8:29am, LVN C checked Resident #75's blood pressure; it was 136/78. LVN C documented that blood pressure on the eMAR and documented that Resident #75 received his Lisinopril. On 03/01/25, 03/02/25, and 03/03/25, Resident #75 was out of the facility; however, on 03/03/25, LVN I documented Resident #75's blood pressure on the eMAR as 136/78, the same BP as 02/28/25, and that Resident #75 did not receive his Lisinopril because he was out of the facility without medications. 2. Record review of Resident #110's admission record reflected a [AGE] year-old male admitted to the facility on [DATE]. Resident #110's diagnoses included systolic (congestive) heart failure (when the heart cannot pump blood effectively through the body and results in decreased blood pressure and sometimes fluid build up in the legs and lungs), fluid overload, non-ST elevation myocardial infarction (a heart attack due to a partially blocked artery in the heart), idiopathic hypotension (low blood pressure), acute kidney failure (a sudden condition in which the kidneys cannot filter waste from the blood), and chronic kidney disease, stage 2 (mild decrease in kidney function). Record review of Resident #110's admission MDS dated [DATE] reflected a BIMS score of 11 which indicated Resident #110 was moderately cognitively impaired. (continued on next page)

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	675717	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Rafael Nursing and Rehabilitation Center	3050 Sunnybrook Rd Corpus Christi, TX 78415

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #110's care plan dated 03/04/25 reflected the focus of altered cardiovascular status r/t CHF, history of NSTEMI with a goal of no complications of cardiac problems through the review date, and interventions which included assess fingers and toes for warmth and color, assess for shortness of breath and cyanosis (blue tint to the lips/skin), diet consult as necessary, and monitor/document/report PRN and s/sx of CAD: chest pain or pressure, heartburn, nausea and vomiting, shortness of breath, excessive sweating, dependent edema (swelling of legs/feet), changes in capillary refill, and color/warmth of extremities, initiated on 02/21/25. The focus of Congestive Heart Failure with goals of clear lung sounds, normal heart rate and rhythm, and less difficulty breathing and interventions which included give cardiac medications as ordered, initiated on 02/21/25. Record review of Resident #110's order summary report reflected the following orders: Metoprolol Tartrate (Blood pressure decreasing medication) Oral Tablet. Give 12.5mg by mouth two times a day for HTN (high blood pressure). Hold if BP <110/60, pulse <60. Start date 02/13/25 at 9:00am. Midodrine HCl (Blood pressure increasing medication) Oral Tablet 10mg. Give 1 tablet orally three times a day for hypotension (low blood pressure). Hold for SBP (the top number in the blood pressure) >120. Start date 02/13/25 at 8:00am. 2a-o. Record review of Resident #110's February and March 2025 blood pressure tab and eMAR, as well as Resident #110's progress notes in PCC reflected the following: On 02/13/24 at 5:02pm, LVN B checked Resident #110's blood pressure; it was 99/53. On 02/13/24 at 7:30pm, LVN E checked Resident #110's blood pressure; it was 153/87 however LVN E documented 99/53 (the 5:02pm BP) as the blood pressure for Resident #110's 11:00pm Midodrine dose and documented that Resident #110 received his 11:00pm Midodrine dose, despite the blood pressure being above hold parameters at 7:30pm. LVN E did not check Resident #110's blood pressure before administering Resident #110's blood pressure increasing medication. On 02/13/25, LVN E documented 99/53 (the 5:02pm BP) as the blood pressure for Resident #110's 9:00pm Metoprolol dose and documented that Resident #110 did not receive his 9:00pm Metoprolol dose due to his blood pressure being outside of parameters for administration, even though LVN E checked Resident #110's blood pressure at 7:30pm and it was 153/87 and the 9:00pm Metoprolol dose would have been given if LVN E had gotten that blood pressure result if he had checked Resident #110's blood pressure between 8:00pm and 10:00pm. On 02/14/25 at 5:53pm, LVN D checked Resident #110's blood pressure; it was 113/65. On 02/14/25, LVN E documented 113/65 (the 5:53pm BP) as the blood pressure for Resident #110's 9:00pm Metoprolol dose and documented that Resident #110 received it. LVN E did not check Resident #110's blood pressure before administering Resident #110's blood pressure decreasing medication. On 02/14/25, LVN E documented 113/65 (the 5:53pm BP) as the blood pressure for Resident #110's 11:00pm Midodrine dose and documented that Resident #110 received it. LVN E did not check Resident #110's blood pressure before administering Resident #110's blood pressure increasing medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/15/25 at 5:22pm, LVN D checked Resident #110's blood pressure; it was 101/59. On 02/15/25, LVN E documented X as the blood pressure for Resident #110's 9:00pm Metoprolol dose and documented Resident #110 did not receive it. LVN E did not check Resident #110's blood pressure before non-administering Resident #110's blood pressure decreasing medication. On 02/15/25, LVN E documented 101/59 (the 5:22pm BP) as the blood pressure for Resident #110's 11:00pm Midodrine dose and documented that Resident #110 received it. LVN E did not check Resident #110's blood pressure before administering Resident #110's blood pressure increasing medication. On 02/16/25 at 5:28pm, LVN D checked Resident #110's blood pressure; it was 108/58. On 02/16/25, LVN E documented 108/58 (the 5:28pm BP) as the blood pressure for Resident #110's 9:00pm Metoprolol dose and documented that Resident #110 did not receive it. LVN E did not check Resident #110's blood pressure before non-administering Resident #110's blood pressure decreasing medication. On 02/16/25, LVN E documented 108/58 (the 5:28pm BP) as the blood pressure for Resident #110's 11:00pm Midodrine dose and that Resident #110 received it. LVN E did not check Resident #110's blood pressure before administering blood pressure increasing medication. On 2/18/25 at 8:51am, LVN B checked Resident #110's blood pressure; it was 96/57. On 02/18/25, LVN B documented 96/57 (the 8:51am BP) as the blood pressure for Resident #110's 4:00pm Midodrine dose and documented that Resident #110 received it. LVN B did not check Resident #110's blood pressure before administering blood pressure increasing medication. On 02/18/25 at 8:39pm, LVN J checked Resident #110's blood pressure; it was 101/52 and LVN J documented that blood pressure for Resident #110's 9:00pm Metoprolol dose and documented that Resident #110 received it, even though Resident #110's blood pressure was below the practitioner ordered parameters to not administer Resident #110's blood pressure decreasing medication. On 02/19/25 at 5:25pm, LVN D checked Resident #110's blood pressure; it was 102/52. On 02/19/25, LVN E documented 102/52 (the 5:25pm BP) as the blood pressure for Resident #110's 9:00pm Metoprolol dose and documented that Resident #110 received it, even though Resident #110's documented blood pressure was below the practitioner ordered parameters to not administer it. LVN E did not check Resident #110's blood pressure before administering blood pressure decreasing medication. On 02/19/25, LVN E documented 102/52 (the 5:25pm BP) as the blood pressure for Resident #110's 11:00pm Midodrine dose and documented that Resident #110 received it. LVN E did not check Resident #110's blood pressure before administering blood pressure increasing medication. On 02/21/25 at 9:43pm, LVN J checked Resident #110's blood pressure; it was 100/56 and LVN J documented that blood pressure for Resident #110's 9:00pm dose of Metoprolol and that Resident #110 received it, even though Resident #110's blood pressure was below the practitioner ordered parameters to not administer Resident #110's blood pressure decreasing medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/22/25 at 9:18am, LVN B checked Resident #110's blood pressure; it was 96/62 and LVN B documented that blood pressure for Resident #110's 9:00am Metoprolol dose and documented that Resident #110 received it, even though Resident #110's blood pressure was below the practitioner ordered parameters to not administer Resident #110's blood pressure decreasing medication. On 02/22/25, LVN B documented 96/62 (the 9:18am BP) as the blood pressure for Resident #110's 4:00pm Midodrine dose and documented that Resident #110 received it. LVN B did not check Resident #110's blood pressure before administering blood pressure increasing medication. On 02/22/25, LVN J documented 96/62 (the 9:18am BP) as the blood pressure for Resident #110's 9:00pm Metoprolol dose and documented that Resident #110 received it even though the documented blood pressure was below the practitioner ordered parameters to not administer. LVN J did not check resident #110's blood pressure before administering Resident #110's blood pressure decreasing medication. On 02/22/25, LVN J documented 96/62 (the 9:18am BP) as the blood pressure for Resident #110's 11:00pm Midodrine dose and documented that Resident #110 received it. LVN J did not check resident #110's blood pressure before administering Resident #110's blood pressure increasing medication. On 02/24/25 at 12:56am, LVN J checked Resident #110's blood pressure; it was 98/56 and LVN J documented that blood pressure for Resident #110's 02/23/25 11:00pm Metoprolol dose and documented that Resident #110 received it, even though Resident #110's blood pressure was below the provider ordered parameters to not administer. On 02/24/25 at 5:21pm, LVN D checked Resident #110's blood pressure; it was 102/61. On 02/24/25, LVN K documented 102/61 (the 5:21pm BP) as the blood pressure for Resident #110's 9:00pm Metoprolol dose and documented that Resident #110 received it even though the documented blood pressure was below the practitioner ordered parameters to not administer. LVN K did not check resident #110's blood pressure before administering Resident #110's blood pressure decreasing medication. On 02/25/25 at 5:29pm, LVN C checked Resident #110's blood pressure; it was 147/62 and LVN C documented that blood pressure for Resident #110's 4:00pm Midodrine dose and documented that Resident #110 received it, even though Resident #110's blood pressure was above the provider ordered parameters to not administer. On 02/25/25 at 8:10pm, LVN L checked Resident #110's blood pressure; it was 108/78 and LVN L documented that blood pressure for Resident #110's 9:00pm Metoprolol dose and documented that Resident #110 received it, even though Resident #110's blood pressure was below the provider ordered parameters to not administer. On 02/25/25 at 11:36pm, LVN L checked Resident #110's blood pressure; it was 122/62. On 02/26/25, LVN I documented 122/62 (the 02/25/25 at 11:36pm BP) as the blood pressure for Resident #110's 8:00am Midodrine dose and documented that Resident #110 received it even though Resident #110's documented blood pressure was above the provider ordered parameters to not administer. LVN I did not check resident #110's blood pressure before administering Resident #110's blood pressure increasing medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/26/25, LVN I documented 122/62 (the 02/25/25 at 11:36pm BP) as the blood pressure for Resident #110's 9:00am Metoprolol dose and documented that Resident #110 received it. LVN I did not check resident #110's blood pressure before administering Resident #110's blood pressure decreasing medication. On 02/26/25, LVN I documented 122/62 (the 02/25/25 at 11:36pm BP) as the blood pressure for Resident #110's 4:00pm Midodrine dose and documented that Resident #110 received it even though Resident #110's documented blood pressure was above the provider ordered parameters to not administer. LVN I did not check resident #110's blood pressure before administering Resident #110's blood pressure increasing medication. On 03/01/25 at 10:05am, LVN C checked Resident #110's blood pressure; it was 119/69. On 03/01/25, LVN C documented X as the blood pressure for Resident #110's 4:00pm Midodrine dose and documented that Resident #110 received it. LVN C did not check Resident #110's blood pressure before administering Resident #110's blood pressure increasing medication. On 03/02/25 at 10:03am, LVN C checked Resident #110's blood pressure; it was 108/60 and LVN C documented that blood pressure for Resident #110's 9:00am Metoprolol dose and documented that Resident #110 received it, even though Resident #110's blood pressure was below the provider ordered parameters to not administer. On 03/03/25 at 9:58am, LVN I checked Resident #110's blood pressure; it was 106/74 and LVN I documented that blood pressure for Resident #110's 9:00am Metoprolol dose and documented that Resident #110 received it, even though Resident #110's blood pressure was below the provider ordered parameters to not administer. On 03/03/25 at 9:18pm, LVN E checked Resident #110's blood pressure; it was 126/82 and LVN E documented that blood pressure for Resident #110's 8:00pm Midodrine dose and documented that Resident #110 received it, even though Resident #110's blood pressure was above the provider ordered parameters to not administer. In an interview on 03/05/25 at 4:21pm, the NP stated she would expect the nurses to follow the provider's hold parameters on medications. The NP stated she would not expect the nurses to notify her or the physician every time a medication was held, because she was in the facility at least once a week and could talk to the nurses then, but if they were holding a medication for 3 or more days in a row, the nurses should at least call her to let her know what is going on. The NP stated it was important for the nurses to administer medications as they were ordered so the resident would receive the therapeutic effects that were intended when that or those medications were prescribed. The NP stated not following prescriber's administration or hold parameters could lead to adverse medication reactions and possibly hospitalization for the resident. In an interview on 03/06/25 at 9:30am, LVN C stated it was important to check blood pressures on every resident that had blood pressure medications to make sure that their pressure was not too low (or too high). LVN C stated she did not have a good reason as to why she sometimes did not check blood pressures on Resident #75 or Resident #110 before administering blood pressure altering medications. LVN C stated she did not recall when the last in-service on medication administration was, but they were pretty often. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/06/25 at 11:24am, LVN D stated they were supposed to check blood pressures before administering any blood pressure altering medications and it was the same with medications that could affect the resident's heart rate. LVN D stated there was no reason to not check vital signs before giving blood pressure medications and it was very dangerous to not check it. LVN D stated it was important to follow provider hold parameters because they did not want to decrease the blood pressure too low or raise it too high. LVN D stated the last in-service on medication administration was within the previous 3 to 4 weeks. In an interview on 03/06/25 at 11:40am, LVN E stated it was important to check blood pressures prior to medication administration to prevent the resident's blood pressure from going too high or too low. LVN E stated if blood pressures were not checked and medications were administered, it could lead to a hypertensive crisis (very high blood pressure) or significant hypotension (very low blood pressure) which could lead to hospitalization or death. LVN E stated when he was on night shift, he would usually use the blood pressure reading that was taken by the day shift nurse because it was at the end of the day shift and close to the time he would start passing his night shift medications. LVN E stated the last in-service on medication administration was last week and they were usually in-serviced every couple of weeks. In an interview on 03/06/25 at 1:35pm, the DON stated his expectation was that the nurses would always check a resident's blood pressure before administering any blood pressure affecting medications and that those medications would not be given if the resident's blood pressure was outside of the parameters set by the provider. The DON stated if any medications were given outside of the provider's set parameters, it could cause a resident to have an adverse medication reaction. In an interview on 03/06/25 at 1:52 pm, ADON F stated her expectation was that the nurses follow the parameters as ordered and to always check and appropriately document vital signs when required. ADON F stated it was important to give medications as ordered to prevent bad outcomes for the residents. ADON F stated they were going to start doing secret monitoring along with weekly audits and the last in-service on medication administration and all the stuff that goes with it was about 3 weeks ago. Record review of the facility's Administering Medications Policy dated December 2012 reflected in part: Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: 3. Medications must be administered in accordance with the orders, including any required time frame. 8. The following information must be checked/ verified for each resident prior to administering medications:

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748 Based on observation, and interview, the facility failed to dispose of expired biologicals in 2 of 2 medication rooms reviewed for storage. The facility failed to discard 19 expired swab kits in the 100-hall medication room. The facility failed to discard an expired enteral feeding tube de-clogger device in the 200-hall medication room. These failures could place residents at risk of infection and diminished quality of life. Findings included: Observation of the 100 hall medication room on [DATE] at 8:32 AM revealed expired medication and specimen swabs: 1 glucagon pen (emergency use for low blood sugar) expired [DATE]. 1 urine-vaginal-STI (sexual transmitted infection) expired [DATE]. 1 wound swab kit expired [DATE]. 4 buccal (mouth) swab kits expired [DATE]. 2 vaginal swab kits expired [DATE]. 3 vaginal swab kits expired [DATE]. 7 wound/tissue swab kits expired [DATE]. Observation of the 200 hall medication room on [DATE] at 8:37 AM revealed 1 enteral feeding tube de-clogger expired [DATE]. In an interview with ADON F on [DATE] at 8:48 AM, she said the expired sterile swabs had lost their sterility and could alter results if used. She said the facility did not use the lab company for several years and had switched to a different lab company. She said someone unknowingly could have used the expired swabs and would cause more problems than helping because there might not be another opportunity to collect a swab for a specific encounter or since the swabs were expired, could potentially introduce bacteria into the resident. She said expired swabs and the de-clogging tube placed residents at risk for infections. She said she was responsible for checking the medication rooms and did not think about removing the swabs because it had been a couple of years since the facility changed companies. A policy for expired biologicals was requested at this time but not received. Best practices for Managing Medical supply expiration dates dated [DATE] titled, Biologicals are made from a variety of natural sources--human, animal, or microorganisms. Biologics are used to treat, prevent, or diagnose diseases and medical conditions .sterile wound swabs are designed to be used to clean wounds and prevent infection. They may include a wide range of products such as vaccines, blood and blood components, allergenics, somatic cells, gene therapy, tissues, and recombinant therapeutic proteins. Once the expiration date passes, the product may no longer be sterile, increasing the risk of introducing harmful bacteria or other pathogens into the wound.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 44748 Based on interview and record review, the facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment for 1 of 5 (RD) qualified dietary staff reviewed. The facility failed to ensure the registered dietician (RD) attended weekly weight meetings. This failure could affect residents who ate food from the kitchen and could result in the dietary needs of residents not being met. The findings included: In an interview with the ADON F on 03/06/25 at 1:52 pm, she said the RD was supposed to visit the facility weekly for weekly weight meetings but came in primarily for monthly meetings. She said the monthly meetings included the RD, ADONs, DM, wound care nurse, the DOR, and the DON. She said the RD did not call in to attend the weekly meetings. She said the RD would often miss meetings. She said dietary was responsible for updating preference cards and likes/dislikes. She said she did not know if the RD met with residents. She said she did not have concerns about weight loss based on the last meeting, which was Friday, 02/28/25 last week. She said when there was a concern for weight loss and the need for supplements or fortified foods the RD would make recommendations to the ADONs, the DM, and DON, then they informed the doctor so he could write the order. She said if a resident needed dietary changes, the ADONs in conjunction with the staff nurses and CNAs would let the doctor know and order a swallow evaluation. In an interview with the DM on 03/06/25 at 2:30 pm, she said she contacted the RD via phone 3-5 times a week and she was somewhat readily available for phone calls. She said the RD rarely attended the weekly weight meetings if at all and had the capacity to call in to them but did not. The DM said, after the RD's stroke in late October/early November 2024, she stopped coming to the weekly weight meetings but had always come to the monthly meetings. The DM said she was responsible for updating the preference cards and likes/dislikes. She said she had seen the RD visit 2 residents in the last year. She said ADON F was the first to bring up trending weight loss. ADON F would tell the DM for more urgent needs and inform the RD if need be. The DM said the RD was all clinical and she did not get involved with kitchen sanitation and food preparation. The DM said the RD did a walk through when she was there for the monthly meetings. The DM said the RD had never in-serviced or provided any training for the staff. The DM said the RD was involved with any changes to the menu because the food changed must be nutritionally equal. The DM said she emailed the RD her suggestions and the RD promptly answered. The DM said the RD's concerns during the walk throughs consisted of her making sure everyone was wearing hairnets, scoop sizes, menu compliance, general cleanliness, emergency supplies, and dry storage. She said the RD did not use a checklist for her walk-throughs. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview with the RD on 03/06/25 at 3:05 pm, she said she visited the facility every Friday, 32 hours a month. She said she communicated with the DM over the phone and would ask the DM if there were any problems. She said she had never done in-services or training with the staff. She said she was not involved with the cleaning schedules. She said she did a quick walk through when she got to the facility on every Friday. She said the DM really knew her stuff and weather the staff followed her instructions was a different story. For example, she said she saw the DM correct someone who had their beard guard under his chin about 4 weeks ago. She said she saw a purse on the shelf of the emergency food closet and a jacket on the door but did not know when. She said she visited residents when she was at the facility and those who were trending with weight loss. She said she could not say how many residents she spoke with every Friday, but it was 4-5 on average. She said she followed up 2 weeks after her recommendations on campus to see if her recommendations were working. The RD said nothing when asked if she could verify her on-site visits. In an interview with the ADM on 03/06/25 at 4:00 pm, he said he thought the RD came to the facility every week for their weekly weight meetings, but he could not validate that. He said he could probably get the sign-in sheets for the weekly weight meetings. He said he was unaware the RD was not going to the weekly weight meetings. Sign in sheets for the weekly weight meetings since October 2024 were requested at this time but not received. Record review of kitchen in-services dated 01/03/25, 02/05/25, 02/07/25, and 02/18/25 were not signed or conducted by the RD. Record review of the facility agreement for consultant dietician services signed and dated by the ADM on 12/13/23 and by the RD on 03/14/22 revealed under Responsibilities of consultant, 1.4 Provide guidance and training to dietary manager and dietary staff as required. 1.8 Inspect all areas of the dietary department, Including sanitatioin, equipment functioning, food service operations, and compliance with pertinent federal state and local laws as desired by Facility. Consultant shall be avialable at various mealtimes to observe dining operations. 1.13 Consultant shall be present for federal or state survey as requested by facility. However, if the presence of consultant is desired, consultant must be notified immediately following the arrival of surveyors to provide assistance in a timely manner.

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	675717	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Rafael Nursing and Rehabilitation Center	3050 Sunnybrook Rd Corpus Christi, TX 78415

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44748 Based on observation, interviews and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed and 2 of 2 nutrition rooms for storage, preparation, and sanitation. The facility failed to use internal thermometers in 2 freezers. The facility failed to maintain cleanliness of shelves, the ice machine, coffee cups, and microwave oven throughout the kitchen. The facility failed to follow a proper cleaning schedule. The facility failed to ensure kitchen utensils were in good working order. The facility failed to ensure dented holding pans were not in use and on the clean rack. The facility failed to ensure the dumpster side doors were kept closed. The facility failed to ensure all containers of food in the refrigerator was labeled. The facility failed to ensure boxes of food were not stacked too close to the ceiling in the walk-in refrigerator. The facility failed to ensure personal items were not on the shelves with dry storage items and canned goods. The facility failed to ensure male staff members with beards and mustaches were wearing their beard guards correctly. The facility failed to ensure a kitchen staff member washed his hands after touching his phone and beard guard before returning to prep in the kitchen. The facility failed to ensure the items in the resident nutrition refrigerators in the 100-hall and 200-hall medication rooms were labeled and dated. The facility failed to maintain one oven door in good working order. The facility failed to maintain proper water temperatures for the dishwashing machine, 3-compartment sink, sanitizer sink, and hand washing sink. These failures could place residents who received meals and/or snacks from the kitchen at risk for food contamination, weight loss, and food borne illness. Findings included: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation and initial tour of the kitchen on 03/04/25 at 8:35 am revealed no internal thermometers in the 3-door freezer or the chest type supplement freezer. The microwave oven a had thick baked on dark brown substance in a splattered pattern on the inside. There was large a wooden handled spatula that had multiple splinters chaffing off the handle. There was a large rubber spatula with pieces missing around the edges. There were 4 heavily dented holding pans in use. The underside of the shelf directly over the stove had a flaking dark red and brown substance. The ice machine had a removable brownish substance on the ice chute. There were dirty cups on a cart used for serving. 2 of 2 dumpsters had the side doors open. The handle on the right side of the oven was loose. There were roaches in the upper mechanical part of the ice machine. The dishwashing machine, 3-compartment sink, sanitizer sink, and hand washing sink were below temperature at 90-100 degrees. Observation and re-visit to the kitchen on 03/05/25 at 9:15 am revealed 1 of 3 containers of food in the refrigerator was dated but not labeled. 5 dented pans remained on a clean rack. 2 large boxes of food were approximately 8 inches from the ceiling in the walk-in refrigerator. There were multiple personal items on the shelves with dry storage items and canned goods: 1 purse, 1 backpack, 3 used aprons, 3 hoodies, a partially full and opened 16-ounce bottle of water, and a thin, tin box of colored pencils. 2 male staff members with beards and mustaches were wearing their beard guards under their chins, exposing their facial hair. 1 staff member did not wash his hands after touching his phone and beard guard before returning to prep in the kitchen. 2 of 2 dumpsters had the side doors open. Observation of the resident nutrition refrigerator in the 100-hall medication room on 03/06/25 at 8:40 am revealed a large partial tray of store-bought sandwiches that was unlabeled and undated. Observation of the resident nutrition refrigerator in the 200-hall medication room on 03/06/25 at 8:44 am revealed two large disposable boxes of food from a local restaurant that were unlabeled and undated. In an interview with the DM on 03/04/25 at 8:45 am, she said she did not know where the thermometers for the freezers were. She said she knew the thermometers were in there, but a shipment was coming today and the staff must have taken them out. She said staff was using the external digital thermometers on the 3-door freezer. She said she was not aware of the dirty microwave or spatulas. She said the microwave should have been cleaned as soon as whoever saw it that way. She said the wood on the spatula was coming off, could get in the food and make residents sick or get stuck in their teeth. She said the rubber spatula had pieces missing from the edges and probably got in the food because the rubber spatula was only used for the pureed foods in the puree machine. She said the holding pans had a lot of dents in them. She said the crevasses could harbor bacteria, which would get in the food and could make residents sick. She said the shelf above the stove was pretty dirty. She ran her fingers on the underside of the shelf and had bits of dark red and black flakes on her fingers. She said the substances were probably rust, could get into the food, and make residents sick or get in their teeth. She said she had cleaned the ice machine not too long ago but could not say when. She said the removable brownish substance on the ice chute was mold. She said the dirty cups were on the serving tray. She said the process for reporting equipment that needed to be repaired or replaced was for her to place the request in the facility's electronic reporting system, the MS received a text, and all requests were discussed in the daily morning meetings. She said staff were following a cleaning schedule, but did not have one posted and said my cleaning schedules are a mess. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The DM said she had been trying to get the handle on the oven door fixed for several weeks. She said the water in the kitchen had not been hot enough since they caught it Sunday 03/02/25. Temperature logs for the last 2 weeks were requested at this time. She said they would start using disposable dishes today. In an interview and re-visit to the kitchen with the DM on 03/05/25 at 9:40 am, she identified a container of egg salad in the refrigerator that was not labeled and the use by date was today. She said the dented pans were not supposed to be in use because they were identified yesterday. She said she would have an in-service including dented pans. She said the boxes in the walk-in refrigerator were supposed to be 18 inches from the ceiling because they could block the sprinklers and become a fire hazard. She said personal items were not allowed in the dry storage area she identified as the emergency food closet. She said staff were supposed to use the hangers behind the door of the closet that was easier to get to than the shelves. She said she had told staff Over and over about this (personal items on the shelves). She said she had in serviced and trained staff about proper use of hair nets and beard guards, handwashing, and personal items. Cleaning schedules, facility policies for safe equipment, Proper disposal of trash, food storage and temperatures, in-services/training, and electronic request logs, were requested at this time. In an interview with DA 1 on 03/05/25 at 9:50 am, she said the purse and one of the hoodies in the emergency food closet belonged to her. She said personal items were not supposed to be stored on the shelves of the emergency food closet or any dry storage area because of cross contamination and make other staff and resident's sick. She said the food she and others touched would have to be thrown away. She said she had been trained on where to store personal items, which was behind the door approximately 2 feet away from the shelves. In an interview with DA 2 on 03/05/25 at 9:55 am, he said the backpack, water, and one of the hoodies belonged to him. He said personal items were not supposed to be stored on the shelves of the emergency food closet because outside items mixed with kitchen items could cause cross contamination and make other staff and resident's sick. He said he had been trained on where to store personal items, which was on the door approximately 2 feet away from the shelves. He said he washed his hands before and after he entered the area where his personal items were kept. In an interview and observation with DA 3 on 03/05/25 at 10:00 am revealed his beard guard was under his chin, exposing his facial hair. He was standing over the main prep table in the kitchen and using his phone with bare hands. He said he forgot to put his beard and mustache guard up because it did not fit properly over his nose. He said exposed hair of any kind could cause cross contamination and make other staff and resident's sick. He said he had been trained on where to store personal items, which was on the door approximately 2 feet away from the shelves in the emergency food closet. He was observed returning to the prep table without washing his hands after touching his face and his phone. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with the MS on 03/05/25 at 3:30 pm, he said the process for reporting kitchen repairs or problems was the problem would be entered into the facility electronic reporting system. He said the ADM, himself, and corporate got a text alert from the electronic reporting system. He said he followed weekly and monthly tasks to stay prioritized. He said it was a collective effort to keep the dumpster doors closed and pick up trash around the dumpster. He said the side doors were to be closed at all times when not in use. The MS said the process for reporting kitchen repairs or problems was the problem would be entered into the facility electronic reporting system. He said the ADM, himself, and corporate got a text alert from the electronic reporting system. He said he followed weekly and monthly tasks to stay prioritized. He said he had work orders for the AC returns. He said one of the 4 water heaters was dedicated to the kitchen, 2 were dedicated to the halls. He said the 4th one was out of commission, and they were trying to source one or get a new one. In an interview with ADON F on 03/06/25 at 8:48 am, she said all items in the resident refrigerators should be dated and labeled with the resident's names. She said she did not know how long the tray of store-bought sandwiches had been in the 100-hall resident refrigerator or who might have put it there. She said the food containers in the 200-hall resident refrigerator should not have been in there if it belonged to a staff member. She said cross contamination of outside unlabeled and undated food items could occur with resident items, and potentially make the residents sick. In an interview with the ADM on 03/06/25 at 4:00 pm, he said he was notified Sunday (03/02/25) regarding the water temperature in the kitchen. He said one of the water heaters had a leak. He said the plumber came out Monday (03/03/25) and said the water heater was fine. The ADM said he checked the water heater after the plumber and that was when he found the water heater was not heating. The ADM said he called the plumber to the facility to check the water heater. The ADM said he did not check the water temperature in the kitchen on Monday (03/03/25). He said paper dishes were used on Monday because the water had not been hot enough to sanitize dishware and could make the residents sick. Record review of the facility's undated Competency Checklist- Dishwasher revealed each dietary personnel received the training and were deemed competent in the following areas: Sanitation, meal service, dishroom, and kitchen safety. Record review of the facility's undated Competency Checklist- [NAME] revealed each dietary personnel received the training and were deemed competent in the following areas: Sanitation, meal service, menus, food orders, and kitchen safety. Record review of the facility's undated Competency Checklist- Dietary Aide revealed each dietary personnel received the training and were deemed competent in the following areas: Sanitation, meal service, menus, food preparation/service, and kitchen safety. Record review of the facility's In-Service Log revealed all dietary personnel received the following in-service and each staff person signed the in-service that indicated receiving the in-service and understanding: 01/03/25 - Topic: Sanitation, uniforms, eating in kitchen 02/05/25 - Fire extinguisher and fire safety 02/07/25 - Cleaning and sanitation, state readiness (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	02/18/25 - Timeliness and attendance Record review of the undated facility's Orientation/Pre-Survey In-service Checklist revealed all dietary personnel were provided the in-service regarding the following topics: Review menu, Tray line sanitation/Tray line Service, Pot and pan sink, Dishwasher, Food storage, Food preparation, and Meal service. Record review of the facility's Daily and weekly cleaning schedules dated 01/01/25-01/31/25 included a 25-task list including can opener, food processsor, cutting boards, prep tables/countertops, beverage table, coffee ursn, pots and pans, stovetop/grill, floor, microwave, handwashing sink, and pot and pan sink. All tasks for all days of the month were checked off as having been done. Record review of the facility's Daily and Weekly cleaning schedules dated 02/03/25-03/01/25 included a 26-task list including for mornings: dining room tables, juice dispenser, tea dispenser, coffee dispenser, thickened beverage dispenser, condiment/silverware bins, ice machine/scoop, 200-hall nutrition refrigerator, ice chest, service doors, and condiment holders. The morning schedule indicated no tasks were done on 02/03, 02/04, 02/06, 02/07, 02/08, or 02/09. For evenings: service carts and trays, dishroom, garbage cans and lids, hand sinks/soap/papertowels, service hall/back dock area, dishroom sinks, floors, mop bucket, mops, dry storage area, storeroom floor, water pitchers, drains, and dishmachine filters. The schedule indicated no tasks were done for 02/03, 02/07, and 02/08. Partial tasks were done the other days of the week for mornings and evenings. Record review of the undated facility kitchen document titled, Policy and Procedure Manual-General HACCP (Hazard Analysis Critical Control Point) Guidelines for Food Safety Ch. 3:Food Production and Safety pg. 3-18 revealed under 9.Refrigerator/Freezer Temperatures a. Take the internal temperatures of each unit. 10. A. Be sure the wash and rinse temperatures are appropriate for the dish machine (Low Temp Type). Under Food Storage pg. 3-22 9. Food will be stored a minimum of 6 inches above the floor, 18 inches from the ceiling, and 2 inches from the wall with adequate space on all sides of stored items to permit ventilation. Racks and other storage surfaces will be clean and protected from splashes, overhead pipes, or other contamination (ceiling sprinklers .etc.) pg. 3-23 11. Leftover food will be stored in covered containers. Each item will be clearly labeled and dated before being refrigerated. 12. Refrigerated food storage: c. Every refrigerator must be equipped with an internal thermometer. F. All foods should be covered, labeled, and dated. Ch. 4 pg. 4-1:Food Safety and Sanitation 2. Employees a. All staff will be in good health, will have clean personal habits and will use safe food handling practices. C. Hair restraints are required and should cover all hair on the head. [NAME] nets are required when facial hair is visible. D. Employees will wash their hands just before they start to work in the kitchen and after smoking, sneezing, using the restroom, handling dirty dishes, touching face, hair, other people or surfaces or items with potential for contamination. Pg. 4-2 Food Storage a. stored food is handled to prevent contamination and growth of pathogenic organisms. Food is protected from contamination (dust, flies, rodents, and other vermin). Pg. 4-29 Pest Control under policy: . Appropriate action will be taken to eliminate any reported pest situation in the department. Pg. 4-21 Dry Storage areas under Policy: Dry storage areas will be maintained to keep food safe and free of infestation or contamination. 4. Ceilings must be free from water .to protect the food from leaking pipes, heat, or contamination. Pg. 4-4 Employee Sanitary Practices under Policy: All food and nutrition services employees will practice good personal hygiene and safe food handling procedures. 1. Wear hair restraints (hairnet, hat, and/or beard restraint to prevent hair from contacting exposed food. 2. Wash hands before handling food .6. Avoid touching mouth or face while preparing food and wash hands if contaminated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	food storage, personal items, nutrition rooms under section 10. Dishwashing a. Be sure the wash and rinse temperatures are appropriate for the dish machine. Record review of facility kitchen policy revised 09/16/16, titled, Food-Related Garbage and Rubbish Disposal 7. Outside dumpsters provided by garbage pick up services will be kept closed . Record review of the facility's undated Competency Checklist- Diet Aide/Wait Staff/Hostess revealed each dietary personnel received the training and were deemed competent in the following areas: sanitation, meal service, specific approved and corporate menus, food preparation/service, and kitchen safety. Record review of the facility's Personal Hygiene and Health Reporting Chapter 4: Sanitation and Infection Control 4-7 policy and procedure dated 03/05/25 reflected Policy: All food and nutrition services employees will be trained on appropriate personal hygiene and health reporting 5. Hair should be neat and clean. Hair restraints must be worn around exposed foods, in the kitchen or food service areas and dining areas. 6. [NAME] and mustaches should be closely cropped and neatly trimmed. When around exposed foods, beards must be restrained using beard covers .9. Hands should be washed in the designated hand washing sinks . References: FDA Food Code 2022 Ch. 2-4 Hygienic Practices 2-401 Food Contamination Prevention 2-401. 11 Eating, Drinking, or Using TOBACCO PRODUCTS an EMPLOYEE shall eat, drink, or use any form of TOBACCO PRODUCTS only in designated areas where the contamination of exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES; or other items needing protection cannot result. (B) A FOOD EMPLOYEE may drink from a closed BEVERAGE container if the container is handled to prevent contamination of: (1) The EMPLOYEE'S hands; (2) The container; and (3) Exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. Ch. 3-305 Preventing contamination from the premises 3-305.11 Food Storage (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination. Ch. 4-202 Cleanability 4-202.11 Food-Contact Surfaces. (A)Multiuse FOOD-CONTACT SURFACES shall be: (1) Smooth; (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections; (3) Free of sharp internal angles, corners, and crevices; 501 Equipment 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. 4-602 Frequency 4-602. 11 Equipment Food-Contact Surfaces and Utensils. (A) Equipment food-contact surfaces and utensils shall be cleaned: (5) At any time during the operation when contamination may have occurred. (C) Except as specified in (D) of this section, if used with TIME/TEMPERATURE CONTROL FOR SAFETY FOOD, EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be cleaned throughout the day at least every 4 hours.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49157 Based on interview and record review, the facility failed to maintain medical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 8 residents (R #75) reviewed for accuracy of records. -The facility failed to ensure LVN C checked and/or documented an accurate blood pressure for Resident #75 before administering Resident #75's blood pressure decreasing medication that had physician ordered hold parameters on 5 of 12 opportunities from 02/01/25 to 03/04/25. -The facility failed to ensure LVN I checked and/or documented an accurate blood pressure for Resident #75 before administering Resident #75's blood pressure decreasing medication that had physician ordered hold parameters on 10 of 11 opportunities from 02/01/25 to 03/04/25. -The facility failed to ensure LVN I did not document a blood pressure reading for Resident #75 when he was not given his blood pressure medication due to being out of the facility on 2 of 2 opportunities from 02/01/25 to 03/04/25. This failure could place residents with falls at risk of not receiving adequate care and services. The findings included: Record review of Resident #75's admission record reflected [AGE] year-old male admitted to the facility on [DATE] with an original admitted [DATE]. Resident #75's diagnoses included essential (primary) hypertension (high blood pressure), hyperlipidemia (high cholesterol), peripheral vascular disease (reduced blood flow to the arms and legs due to narrowed blood vessels), and type 2 diabetes (condition in which the body does not use insulin properly resulting in persistently high blood sugars). Record review of Resident #75's quarterly MDS dated [DATE] reflected a BIMS score of 13 which indicated Resident #75 was cognitively intact. Record review of Resident #75's care plan dated 03/02/24 reflected the focus of, the resident has hypertension (HTN) with the goal, the resident will remain free of s/sx of hypertension through the review date. The interventions included, avoid taking the blood pressure reading after physical activity or emotional distress, and, give anti-hypertensive medications as ordered, monitor for side effects such as orthostatic hypotension (blood pressure decrease when changing position from laying to sitting or sitting to standing) and increased heart rate, and effectiveness, initiated on 03/03/25. Record review of Resident #75's order summary report reflected an order dated 11/20/24 to start on 11/21/24 at 9:00am for Lisinopril (a blood pressure decreasing medication) oral tablet 10mg. Give 1 tablet by mouth one time a day for High B/P. Hold if BP <110/60. Record review of Resident #75's February and March 2025 blood pressure tab and eMAR in PCC reflected Resident #75's blood pressure was checked 9 out of 24 days that Resident #75 was at the facility and received his blood pressure decreasing medication: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/01/25 at 9:43am, LVN C checked Resident #75's blood pressure; it was 136/78. LVN C documented that blood pressure on the eMAR and documented that Resident #75 received his Lisinopril. On 02/02/25 there was no record of Resident #75's blood pressure being checked; however, LVN C documented Resident #75's blood pressure on the eMAR as 136/78, the same BP as 02/01/25, and that Resident #75 received his Lisinopril. On 02/03/25 and 02/04/25, there was no record of Resident #75's blood pressure being checked; however, LVN I documented Resident #75's blood pressure on the eMAR as 136/78 on both days, the same BP as 02/01/25 and 02/02/25 and that Resident #75 received his Lisinopril on both days. On 02/05/25 at 8:56am, LVN C checked Resident #75's blood pressure; it was 141/83. LVN C documented that blood pressure on the eMAR and documented that Resident #75 received his Lisinopril. On 02/06/26, there was no record of Resident #75's blood pressure being checked; however, LVN C documented Resident #75's blood pressure on the eMAR as 141/83, the same BP as 02/05/25, and that Resident #75 received his Lisinopril. On 02/07/25, 02/08/25, and 02/09/25 there was no record of Resident #75's blood pressure being checked; however, LVN I documented Resident #75's blood pressure on the eMAR as 141/83 on all three days, the same BP as 02/05/25 and 02/06/25, and that Resident #75 received his Lisinopril. On 02/11/25 at 10:02am, LVN C checked Resident #75's blood pressure; it was 147/86. LVN C documented that blood pressure on the eMAR and documented that Resident #75 received his Lisinopril. On 02/12/25, there was no record of Resident #75's blood pressure being checked; however, LVN I documented Resident #75's blood pressure on the eMAR as 147/86, the same BP as 02/11/25, and that Resident #75 received his Lisinopril. On 02/13/25, Resident #75 was out of the facility; however, LVN I documented Resident #75's blood pressure on the eMAR as 147/86, the same BP as 02/11/25 and 02/12/25, and that Resident #75 did not receive his Lisinopril because he was out of the facility without medications. On 02/17/25 at 9:12am, LVN M checked Resident #75's blood pressure; it was 145/72. LVN M documented that blood pressure on the eMAR and documented that Resident #75 received his Lisinopril. On 02/18/25, there was no record of Resident #75's blood pressure being checked; however, LVN I documented Resident #75's blood pressure on the eMAR as 145/72, the same BP as 02/17/25, and that Resident #75 received his Lisinopril. On 02/19/25, there was no record of Resident #75's blood pressure being checked; however, LVN C documented Resident #75's blood pressure on the eMAR as 145/72, the same BP as 02/17/25 and 02/18/25, and that Resident #75 received his Lisinopril. On 02/20/25 at 9:11am, LVN C checked Resident #75's blood pressure; it was 146/82. LVN C documented that blood pressure on the eMAR and documented that Resident #75 received his Lisinopril. (continued on next page)

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	675717	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Rafael Nursing and Rehabilitation Center	3050 Sunnybrook Rd Corpus Christi, TX 78415

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/21/25, there was no record of Resident #75's blood pressure being checked; however, LVN I documented Resident #75's blood pressure on the eMAR as 146/82, the same BP as 02/20/25, and that Resident #75 received his Lisinopril. On 02/22/25 and 02/23/25, Resident #75 was not at the facility. On 02/24/25 and 02/25/25, there was no record of Resident #75's blood pressure being checked; however, LVN C documented Resident #75's blood pressure on the eMAR as 146/82, the same BP as 02/20/25 and 02/21/25, and that Resident #75 received his Lisinopril. On 02/26/25 and 02/27/25, there was no record of Resident #75's blood pressure being checked; however, LVN I documented Resident #75's blood pressure on the eMAR as 146/82, the same BP as 02/20/25, 02/21/25, 02/24/25, and 02/25/25, and that Resident #75 received his Lisinopril. On 02/28/25 at 8:29am, LVN C checked Resident #75's blood pressure; it was 136/78. LVN C documented that blood pressure on the eMAR and documented that Resident #75 received his Lisinopril. On 03/01/25, 03/02/25, and 03/03/25, Resident #75 was out of the facility; however, on 03/03/25, LVN I documented Resident #75's blood pressure on the eMAR as 136/78, the same BP as 02/28/25, and that Resident #75 did not receive his Lisinopril because he was out of the facility without medications. In an interview on 03/05/25 at 4:21pm, the NP stated she would expect the nurses to follow the provider's hold parameters on medications. The NP stated she would not expect the nurses to notify her or the physician every time a medication was held, because she was in the facility at least once a week and could talk to the nurses then, but if they were holding a medication for 3 or more days in a row, the nurses should at least call her to let her know what is going on. The NP stated it was important for the nurses to administer medications as they were ordered so the resident would receive the therapeutic effects that were intended when that or those medications were prescribed. The NP stated not following prescriber's administration or hold parameters could lead to adverse medication reactions and possibly hospitalization for the resident. In an interview on 03/06/25 at 9:30am, LVN C stated it was important to check blood pressures on every resident that had blood pressure medications to make sure that their pressure was not too low (or too high). LVN C stated she did not have a good reason as to why she sometimes did not check blood pressures on Resident #75 or Resident #110 before administering blood pressure altering medications. LVN C stated she did not recall when the last in-service on medication administration was, but they were pretty often. An interview was attempted with LVN I on 03/05/25 and 03/06/25 however this state surveyor did not receive a call back from LVN I. In an interview on 03/06/25 at 1:52 pm, ADON F stated her expectation was that the nurses follow the parameters as ordered and to always check and appropriately document vital signs when required. ADON F stated it was important to give medications as ordered to prevent bad outcomes for the residents. ADON F stated they were going to start doing secret monitoring along with weekly audits and the last in-service on medication administration and all the stuff that goes with it was about 3 weeks ago. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Administering Medications Policy dated December 2012 reflected in part: Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: 3. Medications must be administered in accordance with the orders, including any required time frame. 8. The following information must be checked/ verified for each resident prior to administering medications: . b. vital signs, if necessary. According to Lippincott's Nursing Procedures Eigth Edition 2018, pp 236-237 reflected Documentation is the process of preparing a complete record of a patient's care and is a vital tool for communication among health care team members. Accurate, detailed charting shows the extent and quality of care that nurses provide the outcomes of that care, and treatment and education that the patient still needs. Thorough, accurate documentation decreases the potential for miscommunication and errors. Documentation is a valuable method for demonstrating that the nurse has applied nursing knowledge, skills, and judgement according to professional nursing standards.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49157 Based on observations, interviews, and record reviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 5 (Resident #16, Resident #34, Resident #75, Resident #83, Resident #88) of 8 residents reviewed for infection control. 1. The facility failed to ensure LVN C sanitized the blood pressure cuff between use on Resident #83, Resident #88, Resident #34, Resident #75, and Resident #16 on 03/06/25. These failures could place the residents at risk of cross-contamination and development or spread of infection. Findings included: 1. Record review of Resident #83's admission record reflected a [AGE] year-old male that was admitted to the facility on [DATE] with an original admitted [DATE]. Resident #83's diagnoses included unspecified meningitis (inflammation of the tissues surrounding the brain and spinal cord usually caused by an infection), sepsis due to streptococcus pneumoniae (an overwhelming response to an infection that can lead to tissue damage, organ failure, and/or death), essential (primary) hypertension, and history of transient ischemic attack (a mini stroke caused by a brief blockage of blood flow to the brain) and cerebral infarction (stroke). Record review of Resident #83's quarterly MDS dated [DATE] reflected a BIMS score of 12 which indicated that Resident #83 was cognitively intact. Record review of Resident #83's order summary report and eMAR for March 2025 reflected the following orders: Hydrochlorothiazide Oral Tablet 25mg. Give 1 tablet by mouth in the morning for HTN. Start date 02/20/25 at 9:00am. Losartan Potassium Oral Tablet 100mg. Give 1 tablet by mouth one time a day for HTN. Hold if SBP less than 100. Start date 02/19/25 at 9:00am. Norvasc oral Tablet 5mg. Give 5mg by mouth every 12 hours as needed for HTN. Give for systolic b/p over 150. Start date 02/19/25 at 8:45am. Resident #83's eMAR required documentation of his blood pressure and pulse with Hydrochlorothiazide and Norvasc administration. Record review of Resident #88's admission record reflected a [AGE] year-old male admitted to the facility on [DATE] with an original admitted [DATE]. Resident #88's diagnoses included essential (primary) hypertension (high blood pressure), unspecified viral hepatitis (a liver infection that can cause liver inflammation and damage), and hypertensive retinopathy (damage to the blood vessels in the eye caused by high blood pressure). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #88's quarterly MDS dated [DATE] reflected a BIMS score of 15 which indicated Resident #88 was cognitively intact. Record review of Resident #88's order summary report and eMAR for March 2025 reflected an order for Lisinopril Oral Tablet 5mg. Give 1 tablet by mouth one time a day for HTN. Start date 08/03/23 at 9:00am. Resident #88's eMAR required documentation of his blood pressure and pulse with Lisinopril administration. Record review of Resident #34's admission record reflected a [AGE] year-old male admitted to the facility on [DATE] with an original admitted [DATE]. Resident #34's diagnoses included essential (primary) hypertension, atherosclerosis (build up of fats and cholesterol on the walls of the arteries causing obstruction of the blood flow), and hyperlipidemia (high cholesterol). Record review of Resident #34's quarterly MDS dated [DATE] reflected a BIMS score of 00 which indicated that Resident #34 was severely cognitively impaired. Record review of Resident #34's order summary report and eMAR for March 2025 reflected an order for Coreg Tablet 12.5mg. Give 12.5 mg by mouth two times a day for HTN. Hold if BP <110/60. Start dated 01/31/24 at 5:00pm. Resident #34's eMAR required documentation of his blood pressure and pulse with Coreg documentation. Record review of Resident #75's admission record reflected [AGE] year-old male admitted to the facility on [DATE] with an original admitted [DATE]. Resident #75's diagnoses included essential (primary) hypertension (high blood pressure), hyperlipidemia (high cholesterol), peripheral vascular disease (reduced blood flow to the arms and legs due to narrowed blood vessels), and type 2 diabetes (condition in which the body does not use insulin properly resulting in persistently high blood sugars). Record review of Resident #75's quarterly MDS dated [DATE] reflected a BIMS score of 13 which indicated Resident #75 was cognitively intact. Record review of Resident #75's order summary report and eMAR for March 2025 reflected an order for Lisinopril Oral Tablet 10mg. Give 1 tablet by mouth one time a day for high BP. Hold if BP <110/60. Start date 11/21/24 at 9:00am. Resident #75's eMAR required documentation of his blood pressure with Lisinopril administration. Record review of Resident #16's admission record reflected a [AGE] year-old female admitted to the facility on [DATE] with an original admitted [DATE]. Resident #16's diagnoses included essential (primary) hypertension, combined systolic and diastolic (congestive) heart failure (when the heart cannot pump blood effectively through the body and results in decreased blood pressure and sometimes fluid buildup in the legs and lungs), and chronic kidney disease stage 3a (mild to moderate loss of kidney function). Record review of Resident #16's quarterly MDS dated [DATE] reflected a BIMS score of 14 which indicated Resident #16 was cognitively intact. Record review of Resident #16's order summary report and eMAR for March 2025 reflected the following orders: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Cardizem CD oral Capsule Extended Release 24 Hour 120mg. Give 1 capsule by mouth one time a day for hypertension. Hold if BP <110/60, Pulse <60. Start date 02/20/25 at 9:00am. Digoxin Oral Tablet 125mcg. Give 1 tablet by mouth one time a day for A-Fib. Hold if P <60. Start date 02/20/25 at 1:00pm. Resident #16's eMAR required documentation of her blood pressure and pulse with Cardizem administration and documentation of her pulse with Digoxin administration. Observation on 03/06/25 from 8:20am to 9:05am of LVN C during medication pass reflected the following actions: At 08:20am, LVN C took the blood pressure cuff from the top of her medication cart into Resident #83's room. LVN C obtained Resident #83's blood pressure and pulse then returned the blood pressure cuff to the top of her medication cart. LVN C administered Resident #83's medications to him. LVN C administered medications to 2 other residents, then at 8:36am she took the blood pressure cuff from the top of her medication cart into Resident #88's room. LVN C obtained Resident #88's blood pressure and pulse then returned the blood pressure cuff to the top of her medication cart. LVN C administered Resident #88's medications to him. At 8:45am, LVN C took the blood pressure cuff from the top of her medication cart into Resident #34's room. LVN C obtained Resident #34's blood pressure then returned the blood pressure cuff to the top of her medication cart. LVN C administered Resident #34's medications to him. At 8:55am, LVN C took the blood pressure cuff from the top of her medication cart into Resident #75's room. LVN C obtained Resident #75's blood pressure then returned the blood pressure cuff to the top of her medication cart. LVN C administered Resident #75's medications to him. LVN C administered medications to another resident, then at 9:06am LVN C picked up the blood pressure cuff from the top of her cart to take it into Resident #16's room. This surveyor then asked LVN C if there was something she was supposed to do with the blood pressure cuff after she obtained a resident's blood pressure. LVN C stated she was supposed to clean it but she had taken the sanitizing wipes out of her cart and forgot them at the nurse's station. LVN C then went to the nurse's station, retrieved the sanitizing wipes, and wiped down the blood pressure cuff. In an interview on 03/06/25 at 9:15am while the blood pressure cuff was drying, LVN C stated she was supposed to wipe the blood pressure cuff with sanitizing wipes in between each resident, but she had forgotten the canister of wipes at the nurse's station and forgot to clean the cuff. LVN C stated it was important to clean the blood pressure cuff between residents to prevent cross contamination. If the blood pressure cuff was not cleaned between residents it could have led to infection and/ or hospitalization . LVN C stated infection control in-services were every couple of months or more often as needed and last on infection control in-service was last week or the week before. In an interview on 03/06/25 at 11:24am, LVN D stated the blood pressure cuff was to be cleaned in between residents to prevent the spread of infection. LVN D stated she could not recall the last in-service on infection control. In an interview on 03/06/25 at 11:40am, LVN E stated the blood pressure cuff was to be wiped down with disinfecting wipes in between each resident. LVN E stated if it was not cleaned between residents, it could lead to infection being spread. LVN E stated they were in-serviced on infection control weekly and the last one was last week. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/06/25 at 1:35pm, the DON stated his expectation was that the nurses would always clean any equipment used on a resident before it was used on another resident to prevent the spread of bacteria or infection. In an interview on 03/06/25 at 1:52pm, ADON F stated her expectation was disposable or reusable equipment would be cleaned/sanitized between residents to prevent the spread of infection. ADON F stated the last in-service on medication administration and all that goes with it (documentation, cleaning equipment, and such) was done about 3 weeks ago. Record review of the facility's Administering Medications Policy dated December 2012 reflected in part: Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: 22. Staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. 50969 Based on observations, interviews, and record reviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 7 (Resident #16, Resident #34, Resident #43, Resident #66, Resident #75, Resident #83, and Resident #88) of 10 residents reviewed for infection control. 1. The facility failed to ensure LVN C sanitized the blood pressure cuff between use on Resident #83, Resident #88, Resident #34, Resident #75, and Resident #16 on 03/06/25. 2. The facility failed to post Enhanced Barrier Precaution signs outside the rooms for Resident #43 and Resident #66. These failures could place the residents at risk of cross-contamination and development or spread of infection. Findings included: 1. Record review of Resident #83 ' s admission record reflected a [AGE] year-old male that was admitted to the facility on [DATE] with an original admitted [DATE]. Resident #83 ' s diagnoses included unspecified meningitis (inflammation of the tissues surrounding the brain and spinal cord usually caused by an infection), sepsis due to streptococcus pneumoniae (an overwhelming response to an infection that can lead to tissue damage, organ failure, and/or death), essential (primary) hypertension, and history of transient ischemic attack (a mini stroke caused by a brief blockage of blood flow to the brain) and cerebral infarction (stroke). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #83 ' s quarterly MDS assessment dated [DATE] reflected a BIMS score of 12 which indicated that Resident #83 was moderately impaired. Record review of Resident #83 ' s order summary report and eMAR for March 2025 reflected the following orders: Hydrochlorothiazide Oral Tablet 25mg. Give 1 tablet by mouth in the morning for HTN. Start date 02/20/25 at 9:00am. Losartan Potassium Oral Tablet 100mg. Give 1 tablet by mouth one time a day for HTN. Hold if SBP less than 100. Start date 02/19/25 at 9:00am. Norvasc oral Tablet 5mg. Give 5mg by mouth every 12 hours as needed for HTN. Give for systolic b/p over 150. Start date 02/19/25 at 8:45am. Resident #83 ' s eMAR required documentation of his blood pressure and pulse with Hydrochlorothiazide and Norvasc administration. Record review of Resident #88 ' s admission record reflected a [AGE] year-old male admitted to the facility on [DATE] with an original admitted [DATE]. Resident #88 ' s diagnoses included essential (primary) hypertension (high blood pressure), unspecified viral hepatitis (a liver infection that can cause liver inflammation and damage), and hypertensive retinopathy (damage to the blood vessels in the eye caused by high blood pressure). Record review of Resident #88 ' s quarterly MDS assessment dated [DATE] reflected a BIMS score of 15 which indicated Resident #88 was cognitively intact. Record review of Resident #88 ' s order summary report and eMAR for March 2025 reflected an order for Lisinopril Oral Tablet 5mg. Give 1 tablet by mouth one time a day for HTN. Start date 08/03/23 at 9:00am. Resident #88 ' s eMAR required documentation of his blood pressure and pulse with Lisinopril administration. Record review of Resident #34 ' s admission record reflected a [AGE] year-old male admitted to the facility on [DATE] with an original admitted [DATE]. Resident #34 ' s diagnoses included essential (primary) hypertension, atherosclerosis (buildup of fats and cholesterol on the walls of the arteries causing obstruction of the blood flow), and hyperlipidemia (high cholesterol). Record review of Resident #34 ' s quarterly MDS assessment dated [DATE] reflected a BIMS score of 00 which indicated that Resident #34 was severely cognitively impaired. Record review of Resident #34 ' s order summary report and eMAR for March 2025 reflected an order for Coreg Tablet 12.5mg. Give 12.5 mg by mouth two times a day for HTN. Hold if BP <110/60. Start dated 01/31/24 at 5:00pm. Resident #34 ' s eMAR required documentation of his blood pressure and pulse with Coreg documentation. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #75 ' s admission record reflected [AGE] year-old male admitted to the facility on [DATE] with an original admitted [DATE]. Resident #75 ' s diagnoses included essential (primary) hypertension (high blood pressure), hyperlipidemia (high cholesterol), peripheral vascular disease (reduced blood flow to the arms and legs due to narrowed blood vessels), and type 2 diabetes (condition in which the body did not use insulin properly resulting in persistently high blood sugars). Record review of Resident #75 ' s quarterly MDS assessment dated [DATE] reflected a BIMS score of 13 which indicated Resident #75 was cognitively intact. Record review of Resident #75 ' s order summary report and eMAR for March 2025 reflected an order for Lisinopril Oral Tablet 10mg. Give 1 tablet by mouth one time a day for high BP. Hold if BP <110/60. Start date 11/21/24 at 9:00am. Resident #75 ' s eMAR required documentation of his blood pressure with Lisinopril administration. Record review of Resident #16 ' s admission record reflected a [AGE] year-old female admitted to the facility on [DATE] with an original admitted [DATE]. Resident #16 ' s diagnoses included essential (primary) hypertension, combined systolic and diastolic (congestive) heart failure (when the heart cannot pump blood effectively through the body and results in decreased blood pressure and sometimes fluid buildup in the legs and lungs), and chronic kidney disease stage 3a (mild to moderate loss of kidney function). Record review of Resident #16 ' s quarterly MDS assessment dated [DATE] reflected a BIMS score of 14 which indicated Resident #16 was cognitively intact. Record review of Resident #16 ' s order summary report and eMAR for March 2025 reflected the following orders: Cardizem CD oral Capsule Extended Release 24 Hour 120mg. Give 1 capsule by mouth one time a day for hypertension. Hold if BP <110/60, Pulse <60. Start date 02/20/25 at 9:00am. Digoxin Oral Tablet 125mcg. Give 1 tablet by mouth one time a day for A-Fib. Hold if P <60. Start date 02/20/25 at 1:00pm. Resident #16 ' s eMAR required documentation of her blood pressure and pulse with Cardizem administration and documentation of her pulse with Digoxin administration. Observation on 03/06/25 from 8:20am to 9:05am of LVN C during medication pass reflected the following actions: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 08:20am, LVN C took the blood pressure cuff from the top of her medication cart into Resident #83 ' s room. LVN C obtained Resident #83 ' s blood pressure and pulse then returned the blood pressure cuff to the top of her medication cart. LVN C administered Resident #83 ' s medications to him. LVN C administered medications to 2 other residents, then at 8:36am she took the blood pressure cuff from the top of her medication cart into Resident #88 ' s room. LVN C obtained Resident #88 ' s blood pressure and pulse then returned the blood pressure cuff to the top of her medication cart. LVN C administered Resident #88 ' s medications to him. At 8:45am, LVN C took the blood pressure cuff from the top of her medication cart into Resident #34 ' s room. LVN C obtained Resident #34 ' s blood pressure then returned the blood pressure cuff to the top of her medication cart. LVN C administered Resident #34 ' s medications to him. At 8:55am, LVN C took the blood pressure cuff from the top of her medication cart into Resident #75 ' s room. LVN C obtained Resident #75 ' s blood pressure then returned the blood pressure cuff to the top of her medication cart. LVN C administered Resident #75 ' s medications to him. LVN C administered medications to another resident, then at 9:06am LVN C picked up the blood pressure cuff from the top of her cart to take it into Resident #16 ' s room. This surveyor then asked LVN C if there was something she was supposed to do with the blood pressure cuff after she obtained a resident ' s blood pressure. LVN C stated she was supposed to clean it but she had taken the sanitizing wipes out of her cart and forgot them at the nurse ' s station. LVN C then went to the nurse ' s station, retrieved the sanitizing wipes, and wiped down the blood pressure cuff. In an interview on 03/06/25 at 9:15am while the blood pressure cuff was drying, LVN C stated she was supposed to wipe the blood pressure cuff with sanitizing wipes in between each resident, but she had forgotten the canister of wipes at the nurse ' s station and forgot to clean the cuff. LVN C stated it was important to clean the blood pressure cuff between residents to prevent cross contamination. If the blood pressure cuff was not cleaned between residents it could have led to infection and/ or hospitalization . LVN C stated infection control in-services were provided every couple of months or more often as needed and last on infection control in-service was last week or the week before. In an interview on 03/06/25 at 11:24am, LVN D stated the blood pressure cuff was to be cleaned in between residents to prevent the spread of infection. LVN D stated she could not recall the last in-service on infection control. In an interview on 03/06/25 at 11:40am, LVN E stated the blood pressure cuff was to be wiped down with disinfecting wipes in between each resident. LVN E stated if it was not cleaned between residents, it could lead to infection being spread. LVN E stated they were in-serviced on infection control weekly and the last one was last week. In an interview on 03/06/25 at 1:35pm, the DON stated his expectation was that the nurses would always clean any equipment used on a resident before it was used on another resident to prevent the spread of bacteria or infection. In an interview on 03/06/25 at 1:52pm, ADON F stated her expectation was disposable or reusable equipment would be cleaned/sanitized between residents to prevent the spread of infection. ADON F stated the last in-service on medication administration and all that went with it (documentation, cleaning equipment, and such) was done about 3 weeks ago. 2. Record review of Resident #43 ' s face sheet dated 03/05/25 revealed [AGE] year-old male with an admitted [DATE]. (continued on next page)

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	675717	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #43 ' s physician orders revealed an order dated 02/03/25 for Enhanced Barrier Precautions and an order dated 02/27/25 for wound care to left heel. Record review of Resident #43 ' s quarterly MDS assessment dated [DATE] revealed a BIMS of 11, which revealed moderately impaired cognition. Record review of Resident #43 ' s care plan revealed Enhanced Barrier Precautions care plan initiated 04/26/24 and revised on 03/04/25. The care plan also indicated the resident was resistive to wound care initiated 07/12/24 and revised on 01/30/2025. Record review of Resident #66 ' s face sheet dated 03/06/25 revealed a [AGE] year-old male with an original admitted [DATE], and a current admitted [DATE]. Record review of Resident #66 ' s physician orders dated 01/31/25 revealed an order for a Foley catheter and an order for Enhanced Barrier Precautions. Record review of Resident #66 ' s annual MDS assessment dated [DATE] revealed a BIMS of 05, which revealed severely impaired cognition. Record review of Resident #66 ' s care plan initiated 07/16/24 revealed a care plan for Enhanced Barrier Precautions and a care plan for an indwelling catheter initiated on 07/16/24 and revised on 03/04/25. During an observation on 03/04/25 at 11:11 AM of Resident #43 ' s room, revealed there were no Enhanced Barrier Precaution signs posted on the door or the wall outside of Resident #43 ' s room. During an observation on 03/04/25 at 11:34 AM of Resident #66 ' s room, revealed there were no Enhanced Barrier Precaution signs posted on the door or the wall outside of Resident #66 ' s room. In an interview with LVN-N on 03/04/25 at 11:20 AM, he stated if there was no sign outside the resident ' s room on the door or wall, he was not sure how he would tell that a resident was on EBP. He stated he could tell they were probably on some type of precautions by the PPE cart outside of the room, but without seeing the sign he would not have known which precautions the cart was for. He stated that residents that had things such as wounds or Foley catheters should be on EBP as opposed to just standard precautions because there could be cross-contamination if not. In an interview with LVN-B on 03/04/25 at 11:25 AM, he stated there were no signs on any of the EBP rooms, but there should be. He stated there was no way for anyone to be able to tell that a resident was on EBP when entering the room. He stated that most of the rooms had the EBP precautions on the inside of the room, but not on the outside. He also stated that someone would be able to tell that a resident was on some type of precautions because there was a PPE cart outside of the room, but they would not be able to be sure of the exact type of precaution until they had seen the sign inside the resident ' s room. He stated EBP precautions were put into place to help prevent cross-contamination and spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with LVN-G on 03/04/25 at 11:35 AM, she stated she was not sure why Resident #66 ' s door or wall did not have an EBP sign. She stated there should have at least been a sign in the room posted over the bed, but there was not. She stated the signs should be posted outside the residents ' rooms on either the door or the wall to notify other staff of the precautions needed prior to entering the room. That was done to help prevent cross-contamination and the spread of infection. She stated the ADON and DON were in charge of handling and placing EBP signs. In an interview on 03/05/25 at 8:35 AM with ADON-H, he stated standard precautions was using gloves with any residents, and EBP was for things such as open wounds, catheters, and g-tubes. He stated the EBP carts went outside door or near the room hung above the bed to be able to identify the resident had EBP. He stated that their policy allowed the facility to communicate to staff which residents required the use of EBP, but it was not specific to the way they communicated it. He stated he was not sure what the CDC requirement specifically was for EBP signs, but he realized that the signage needed to be posted outside the room on the wall or door so that others knew which precautions to take prior to entering the room. In an interview on 03/06/25 at 2:15 PM with ADON-F, she stated EBP was used for residents that needed more than standard precautions, such as wounds, catheters, or g-tubes. She stated that signs should be posted visibly outside of the resident ' s rooms so that staff could determine which protocol to use and what PPE to put on prior to entering the resident ' s rooms. She stated the signs were previously inside the residents ' rooms above the beds but realized they should be posted outside the room on the door or wall next to the door. Record review of CDC Guidelines: Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), updated 07/12/22, revealed Enhanced Barrier Precautions (EBP) were an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions included: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care: any skin opening requiring a dressing When implementing Contact Precautions or Enhanced Barrier Precautions, it was critical to ensure that staff had awareness of the facility ' s expectations about hand hygiene and gown/glove use, initial and refresher training, and access to appropriate supplies. To accomplish this: *Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) *Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g., gown and gloves) *For Enhanced Barrier Precautions, signage should also clearly indicate the high-contact (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident care activities that required the use of gown and gloves https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html Record review of the Enhanced Barrier Precautions policy, dated 04/2024, revealed EBP precautions were implemented for the prevention of transmission of multidrug-resistant organisms. The facility had the discretion on how to communicate to staff which residents required the use of EBP, as long as staff were aware of which residents required the use of EBP prior to providing high-contact care activities.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 44748 Based on observation, interview, and record review, the facility failed to provide a safe, clean, and sanitary environment for 1 of 1 kitchen. The facility failed to maintain an electrical outlet, lighting fixture, and two AC ducts from dripping water and water damage in the kitchen. These failures could place residents at risk for exposure to an unclean, unsanitary environment, risk of falls and other injuries due to an unsafe environment. The findings included: Observation and initial tour of the kitchen on 03/04/25 at 8:35 am revealed there was an electrical conduit box and a lighting fixture in the ceiling above the stove that were dripping water. The nearby AC return was dripping water. Observation and re-visit to the kitchen on 03/05/25 at 9:15 am revealed the AC return on the ceiling of the DM's office appeared to have water damage to the sheetrock around the frame, which was swollen and gaping open. In an interview and observation with the MS on 03/04/25 at 8:55 am, he said the leak around the electrical conduit, AC return, and lighting fixture had been dripping condensation for about 3 months because the stove was nearby. He said he tried to patch it up and was not aware the water continued to drip. He said he did walk throughs of the kitchen weekly and had not noticed any leaks. The MS was on a ladder and filling in the holes in the electrical conduit box with what appeared to be caulk. He said if he filled in the holes, condensation would continue to collect in the electrical conduit box and have nowhere to drain. He said the condensation could spark with the electrical wires in the box and cause a fire. In an interview with the ADM on 03/06/25 at 4:00 pm, he said one of the water heaters had a leak. He said the plumber came out Monday (03/03/25) and said the water heater was fine. The ADM said he checked the water heater after the plumber and that was when he found the water heater was not heating. The ADM said he called the plumber to the facility to check the water heater. The ADM said he did not check the water temperature in the kitchen on Monday (03/03/25). He said paper dishes were used on Monday because the water had not been hot enough to sanitize dishware and could make the residents sick. Record review of the undated facility kitchen document titled, Policy and Procedure Manual-General HACCP (Hazard Analysis Critical Control Point) Guidelines for Food Safety Ch. 4. Ceilings must be free from water . to protect the food from leaking pipes, heat, or contamination. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	References: FDA Food Code 2022 Ch. 3-305 Preventing contamination from the premises (2) Where it is not exposed to splash, dust, or other contamination. Ch. 4-501 Equipment 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 44748 Based on observations, interviews, and record reviews, the facility failed to maintain effective pest control for 1 of 1 kitchen reviewed for pests. The facility failed to have pest control effectively treat the kitchen for roaches. This deficient practice could place residents at risk of exposure to pests, diseases, infections, and diminished quality of life. Findings included: Observation and initial tour of the kitchen with the DM on 03/04/25 at 8:35 am revealed there were roaches in the upper mechanical part of the ice machine. She opened the upper part of the ice machine, and a roach ran across the opening, then several more roaches emerged from under the front edging. She said the roaches could carry diseases and could make the residents sick. In an interview with the DM on 03/04/25 at 8:45 am, she said the process for reporting equipment that needed to be repaired or replaced was for her to place the request in the facility's electronic reporting system, the MS received a text, and all requests were discussed in the daily morning meetings. Observation and re-visit to the kitchen on 03/05/25 at 9:15 am revealed there were roaches crawling on the floor under the oven and in the outer hallway under the dirty tray carts. There was a screw in the upper section of the ice maker to prevent it from opening. In an interview with the DM on 03/05/25 at 9:40 am, she said the roaches under the stove were a problem because they always seemed be there. She said a roach fell from the AC return in her office onto her head two days ago and she had to move her desk from underneath the AC return. She said the pest control company came every Thursday and the MS kept the invoices. In an interview with the MS on 03/05/25 at 3:30 pm, he said roaches were a problem since he got here 01/13/25. He said there were only hot spots in some rooms but not everywhere. He said there was weekly pest control. He said he was not aware of the pest sighting logs. He said his experience at the facility was that sometimes roaches came in on the residents' belongings. He said he called the pest control company whenever anyone said there was a lot of roaches somewhere and he had to call for that only twice; Monday (03/03/25) for the kitchen on the wall next to the stove under the sink, and 3 weeks ago in the dresser of a resident's room. The MS said the pest control company drilled holes into the wall earlier last month so the spray could better penetrate. He said he had never met the pest control guy until today when he came out for the roaches in the kitchen. The MS said today he saw some roaches under the stove when he was fixing the oven handle. He said he was unaware of the roaches in the hallway outside the kitchen under the dirty tray carts. He said the process for reporting kitchen repairs or problems such as pest control, was the problem would be entered into the facility electronic reporting system. He said the ADM, himself, and corporate got a text alert from the electronic reporting system. He said he did not have the invoices for pest control and did not know who would. Electronic request logs, and pest control logs since 01/01/25 were requested at this time. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with the ADM on 03/06/25 at 11:45 am, he said the local pest control treated the entire facility every week on Thursdays and as needed. He said pest prevention was done each time a complaint was made and logged onto the pest sighting logs which were kept in each nurse's station-1 in the 100 hall and 1 in the 200 hall. He said the process to report any kind of bug was the sightings were logged, the pest control company looked at the logs weekly and treated accordingly. He said he had invoices from when the pest control company came to the facility outside of their normal Thursday visits. Pest prevention service reports outside of regular visits requested at this time but not received. In a phone interview with the RD on 03/06/25 at 3:05 pm, she said she had never seen roaches in the kitchen but knew they were there because the DM told her. In an interview with the ADM on 03/06/25 at 4:00 pm, He said the pest control company told him they could not use the same chemical in a certain period and that was why the pest control company had to come back so often. Record review of the facility's pest sighting log dated 01/03/24-03/05/25 from the 200 hall revealed sightings of roaches in the kitchen on 03/04/25 and 03/05/25. The pest sighting log dated 02/04/25-03/05/25 from the 100 hall revealed sightings of roaches in the kitchen on 02/04/25 in the dry storage emergency food closet, 02/05/25 roaches and mice in the dry storage emergency food closet, 03/03/25 3 mice were found in the dry storage room bread box, 03/03/25 roaches in the dietary office at 8:30 am and 10:00 am, 03/04/25 roaches in the ice machine, and 03/05/25 roaches under the ovens. Record review of the facility's pest prevention kitchen service report dated 03/05/25 indicated the facility interior was inspected, cracks and crevices on interior were treated and baited for roaches. Record review of the facility's Pest Sighting Logs dated 07/15/23 through 03/05/25 revealed eight sightings of roaches in the kitchen: 07/20/23 flies/roaches in kitchen under cooks side, 12/20/23 mice and roaches in kitchen area, 07/24/24 roaches in serving area, 08/06/24 roaches in kitchen, 06/11/24 roaches-kitchen, 06/27/24 roaches/gnats kitchen, 09/19/24 roaches behind oven and deep fryer, 10/01/24 roaches in kitchen.